



GEORGIA BOARD OF NURSING

237 Coliseum Drive
Macon, Georgia 31217
Telephone: (478) 207-2440
Fax: 1-877-371-5712
Web Site: www.sos.ga.gov/plb/nursing

Information Sheet for Licensure as a Registered Professional Nurse by Examination for Graduates of Nontraditional Nursing Education Programs

GENERAL INFORMATION

***** WHEN MAILING APPLICATION TO BOARD OFFICE, PLEASE MAIL IN A 9X12 ENVELOPE & DO NOT STAPLE OR FOLD APPLICATION.*****

The following instructions are provided to assist you in completing your application for licensure by examination (NCLEX). Read all instructions carefully and respond to each question on your application.

You are responsible for ensuring that all information required to apply for licensure by examination is received by Georgia Board of Nursing ("Board"). Assistance with the application process by any third party will in no way lessen your responsibility. Failure to follow procedures may delay your eligibility to take the NCLEX-RN (National Council Licensure Examination for Registered Nurses).

APPLICATIONS INSTRUCTIONS

Legal Name: The name on the application submitted to the Georgia Board of Nursing must be the same as name submitted to the testing service on your NCLEX examination registration form. If the name is not the same on all forms, please provide the Board with the necessary legal documentation. **The picture identification that you will present at the test center must match the name on your licensure application.**

Residential/Mailing Address: A residential (physical) address **is required** for all licenses. You **may not provide** a PO Box for the address. Provide a complete address. If you provide a PO Box mailing address, you must also supply us with a physical address as well. If you are granted a license, your name, license number, mailing address are public information and will be accessible on the Secretary of State's website for purposes of licensure verification, pursuant to O.C.G.A. 43-1-2 (k). **You are required to notify the Georgia Board of Nursing of an address change within 30 days. Sending a notice to the U.S. Postal Service will not fulfill this requirement.** You may update your address by visiting our website at www.sos.ga.gov/plb/nursing or by submitting the change, in writing, to the Board office.

Social Security Number: This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §§19-11-1 et seq. and O.C.G.A. §§20-3-295 et seq., 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB), other licensing boards, and other regulatory agencies for license tracking purposes.

Email Address: Email is the primary means to communicate application deficiencies and resolve issues with your application. It is your responsibility to update your email address with the Board office. You may process these changes at www.sos.ga.gov/plb/nursing. Your email address will not be shared with third parties.

Board Disciplinary Actions/Legal Convictions: If you respond "yes" to the legal/discipline question(s), include certified copies from the appropriate court(s) or agency in a sealed envelope with your application. Be sure to include a detailed explanation of each offense with the application.

Official Transcript: An official (sealed) transcript that includes **your graduation date and the degree conferred** from an approved nursing program must be submitted with your application to the Board. An approved non-traditional nursing education program must meet the requirements set forth in O.C.G.A. §43-26-7(e)

APPLICATION

A complete application includes the non-refundable application fee of \$40.00 payable (by check or money order) to the Georgia Board of Nursing, official sealed transcript(s), any letters of explanation, and certified court documents. Applicants must have been fingerprinted at an approved GAPS service site. Results of the fingerprint-based criminal background check will be electronically transmitted to the Board.

GRADUATES OF A NONTRADITIONAL NURSING EDUCATION PROGRAMS

Graduates of a nontraditional nursing education program who do not meet the educational and practice requirements as stated by Georgia law will be required to complete a Board approved preceptorship. Please refer to the Georgia Board of Nursing website at www.sos.ga.gov/plb/nursing under "Download Forms" to review Instructions for Nontraditional Nursing Education Programs Applicants.

FINGERPRINT-BASED CRIMINAL BACKGROUND CHECK

Criminal background checks are required by O.C.G.A. § 43-26-7 for each application submitted. Refer to the Georgia Board of Nursing website at www.sos.ga.gov/plb/nursing under "Download Forms" for "Instructions for Applicants in the State of Georgia to Obtain Fingerprints for a Background Check" and "Instructions for Out of State Applicants to Obtain Fingerprints for a Background Check." Both in state and out of state applicants must register with Cogent Systems and follow the guidelines found at their website at www.ga.cogentid.com. **DISCLAIMER: The Georgia Board of Nursing is not responsible for unacceptable or rejected fingerprints submitted; it is the vendor's responsibility to provide acceptable fingerprints.**

DISABILITY

If you have a disability and may require an accommodation, refer to the Board's website at www.sos.ga.gov/plb/nursing under "Download Forms" to obtain the REQUEST FOR DISABILITY ACCOMMODATION GUIDELINES. Please be aware that this request may extend the application process in order to obtain the necessary approvals.

TEMPORARY PERMITS

Once a proposed plan for preceptorship is approved by the Board, a six (6) month temporary permit may be issued to the applicant. The applicant is expected to complete the preceptorship within six (6) months. Upon receipt of a written request from the applicant and an updated clinical schedule provided by the Agency Coordinator, a temporary permit may be renewed only one time for an additional six (6) month period.

NCLEX-RN REGISTRATION

Register and pay the examination fee to the testing service when you submit your application to the Board office. You can view the Candidate Information Bulletin at www.ncsbn.org. You can register with the testing service online at www.pearsonvue.com/nclex. Your application review will be delayed if you have not registered with the testing center when your application is initially reviewed by the board staff. Entering the correct school code is critical. Please enter this information carefully and do not leave blank. **NOTE:** A school with more than one type of RN educational program may have more than one code so carefully select the correct code from the candidate bulletin.

EXAMINATION RESULTS

Only failed examination results will be mailed to applicants. Notify the Board immediately, in writing, if you have an address or name change. Name changes require submission of appropriate legal documents. **NO EXAMINATION RESULTS WILL BE GIVEN BY TELEPHONE.** Failed score results will be mailed approximately (1) one month after the examination.

DISCIPLINARY REVIEW

Your application is subject to Board review if you answered "yes" to any legal/discipline question. Your application is not complete until a certified copy of the final disposition and a detailed letter of explanation regarding legal/disciplinary issue(s) is received.

TO RE-APPLY

If you do not pass the NCLEX-RN, you may access the web site at www.sos.ga.gov/plb/nursing for a Repeat Application for Licensure by Exam or contact the Georgia Board of Nursing at (478) 207-2440 for an Application for Licensure by Repeat Examination - U.S. Graduates. **NOTE: Repeat writers are eligible to retest 45 days after the last test date.**

TIME LIMIT ON PASSING NCLEX-RN

You must pass the NCLEX-RN within a three (3) year period from the date of graduation.

LICENSURE

The Professional Licensing Boards will no longer print and mail pocket cards to licensees. Licensees may visit the Board's website at www.sos.ga.gov/plb/nursing, click on "Print License" and follow the on screen instructions to print a copy of your pocket card. The license will display your permanent Georgia license number that is preceded by the letters "RN". This number must be used on all correspondence addressed to the Board and will not change during one's lifetime.

RENEWAL

THE BOARD WILL NOT MAIL RENEWAL NOTICES. It is your responsibility to renew your license on or prior to the expiration date. Paper renewals will only be available by request. If you need a paper renewal, you may contact the Georgia Board of Nursing at (478) 207-2440.

FOR BOARD USE ONLY
 Amount Submitted _____
 Date _____
 Receipt # _____



FOR BOARD USE ONLY
 Certificate Number _____
 Date Issued _____
 Applicant No. _____

GEORGIA BOARD OF NURSING
 237 Coliseum Drive • Macon, Georgia 31217 • (478) 207-2440
www.sos.ga.gov/plb/rn

APPLICATION FOR LICENSURE AS A REGISTERED PROFESSIONAL NURSE BY EXAMINATION FOR GRADUATES OF NONTRADITIONAL NURSING EDUCATION PROGRAMS

License Type: (X) Initial RN
 Method Obtained by: () U.S. Graduate

Part I: Personal Information:

1. Legal Name to appear on License: _____
 LAST FIRST MIDDLE MAIDEN

2. Name as shown on exam records, transcripts or any documentation provided to the Board including maiden name (if different): _____
 LAST FIRST MIDDLE MAIDEN

3. Social Security #: _____ - _____ - _____ Date of Birth: M M - D D - Y Y Y Y
*This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §19-11-1 and O.C.G.A. §20-3-295, 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.

4. Gender: ☐ Male ☐ Female

5. Residential (Physical) Address: _____
 NUMBER AND STREET (P.O. BOX NOT ACCEPTABLE) APT #
 CITY STATE ZIP

6. Mailing Address*: _____
 NUMBER AND STREET (P.O. BOX ACCEPTABLE) APT #
 CITY STATE ZIP
*Pursuant to O.C.G.A. §43-1-2 (k) your name, mailing address and license number are public information and will appear on the Secretary of State's website.

7. Daytime Phone #: _____ - _____ - _____ Evening Phone #: _____ - _____ - _____

8. E-mail Address*: _____ Fax Number: _____
*Used by the Board to contact you concerning your license. Your e-mail address will not be shared with third parties.

9. APPLICANT AFFIDAVIT:

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia State Board of _____, and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

- 1) _____ I am a United States citizen 18 years of age or older. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on page ____ of the application.**
- 2) _____ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of _____ and/or criminal prosecution.

10. Country of Birth: _____

PREVIOUS APPLICATION INFORMATION

11. Have you previously applied to take a licensing examination to become a registered nurse in this or any other state?
☐ No ☐ Yes

If "yes", in which state(s) have you taken the National Council Licensure Examination (NCLEX-RN)? Use additional sheets of paper if needed. Record your name and SSN on each additional sheet of paper.

State	Date	State	Date

EDUCATIONAL INFORMATION

12. List all Nursing schools attended:

Name of School	City /State/Zip Code	Did you Graduate?
		<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes

13. Education Completed: (Check all that apply):

Education Completed Prior to Entering the Non-Traditional Education Program	RN Degree Conferred
<input type="checkbox"/> Military Medical Corpsman <input type="checkbox"/> Paramedic <input type="checkbox"/> LPN <input type="checkbox"/> Other	<input type="checkbox"/> Diploma <input type="checkbox"/> Associate Degree <input type="checkbox"/> BSN <input type="checkbox"/> Master's Degree in Nursing <input type="checkbox"/> Doctoral Degree in Nursing

OFFICIAL TRANSCRIPTS/CERTIFICATES

14. Submit official transcripts in a sealed envelope verifying your enrollment/graduation date from each nursing education program and copies of all program certificates obtained with course descriptions. **(Must be submitted with this application.)**

EMPLOYMENT HISTORY

15. Employment History:

- A. If you entered the non-traditional education program as a licensed practical nurse, your immediate supervisor must be able to document two years of practice within the five years preceding the date of application. This practice must have been completed in an acute care inpatient facility or long term acute care facility. Applicants who cannot provide this documentation will be required to complete a preceptorship as determined in O.C.G.A. §43-26-7.
- B. If you entered the non-traditional education program as a military medical corpsman, you must be able to document two years of experience.
- C. If you entered the non-traditional education program as a paramedic, you must be able to document at least two years of experience as a paramedic prior to entering the non-traditional education program.

The Board of Nursing makes licensure decisions based on the information submitted on this application. A verification of employment form must be provided for each employer. Board Rule 410-6.02 defines one year as a minimum of 1800 hours.

Employer's Name/Address	Actual Workplace Location Facility Name/City/State	Dates From - To (mo/yr)-(mo/yr)	Approximate Calculation of Hours Worked
A.			
B.			
C.			

PREVIOUS DISCIPLINARY AND CRIMINAL CONVICTION INFORMATION

16. Board Disciplinary Actions/Legal Convictions: Answer **BOTH** Questions:

- A. Have you ever been arrested or convicted of a felony, misdemeanor (other than a minor traffic violation), crime involving moral turpitude, or a crime violating federal or state law relating to controlled substances or dangerous drugs? (DWI and DUI are not minor traffic violations.) For purposes of this question, a "conviction" includes a finding of verdict of guilty, plea of guilty, a plea of nolo contendere, or first offender treatment, and also includes adjudication of guilt or sentence withheld or not entered on the charge (s). **NOTE: The answer to this question is "YES" if an arrest or conviction has been pardoned, expunged, dismissed or deferred, you pled & completed probation under First offender and/or your civil rights have been restored and/or you have received legal advice that the offense will not appear on your criminal record.**

☐ No Yes ☐

If "yes," please include a certified copy of the court records and final disposition in a sealed envelope from the court with your application. In the event the file no longer exists, you must submit documentation from the court stating that fact.

Have you included a personal, detailed letter explaining each incident? ☐ No Yes ☐

- B. Have you undergone treatment for drug or alcohol abuse within the last five years? ☐ No Yes ☐

If "Yes," submit a personal letter of explanation regarding the incident. Also include all information relevant but not limited to your diagnosis, prognosis, psychosocial history, treatment recommendations, drug screen results and discharge summary. You must pay any cost associated with the production of the documentation.

- C. Has any licensing board or agency in Georgia or any other state ever:

- | | | |
|---|-----------------------------|------------------------------|
| (a) Denied your application for licensure, renewal, or reinstatement? | <input type="checkbox"/> No | Yes <input type="checkbox"/> |
| (b) Revoked, suspended, restricted, sanctioned, or probated your license? | <input type="checkbox"/> No | Yes <input type="checkbox"/> |
| (c) Requested or accepted surrender of your license? | <input type="checkbox"/> No | Yes <input type="checkbox"/> |
| (d) Reprimanded, fined, or disciplined you? | <input type="checkbox"/> No | Yes <input type="checkbox"/> |

If "**yes**", have you included a **certified copy** of that board or agency's action against your license with relevant supporting documents in a **sealed envelope from the board or agency** with your application?

☐ No Yes ☐

Have you included a **personal, detailed letter** explaining each incident? ☐ No Yes ☐

Provide the name of the agency or board in the space provided.

Name of agency or board

AFFIDAVIT OF APPLICANT

17. I, _____, certify that I am the person described and identified in this application. I have answered all the questions truthfully and completely, and any documents that I have provided in support of my application are, to the best of my knowledge, true and accurate.

I hereby authorize the Georgia Board of Nursing to perform and to receive any criminal history record pertaining to me, which may be in the files of any state or local criminal justice agency in Georgia or any other State or Territory.

Under penalties of perjury, I understand that any false or misleading information in, or in connection with my application, may be cause for denial or revocation of licensure.

(Applicant's Full Name - Printed)

(Signature of Applicant)

(Date Signed)

State of _____ County of _____
(City/Zip)

Applicant signature and notarization should occur on the same date.

Sworn to and subscribed before me this

_____ day of _____, 20 _____.

(Notary Public)

My Commission Expires: _____

(Notary Seal)

Mail this form and application fee to: 237 Coliseum Drive, Macon, GA 31217. DO NOT SEND CASH. Make check or money order payable to the Georgia Board of Nursing. Please do not staple or fold application when mailing to the Board office.

- ☐ Have you paid the fee and registered with the testing service for the NCLEX-RN examination?
- ☐ Is the name you registered with the test service exactly as you have listed it on your application for licensure by examination?
- ☐ Answered every question or indicated "Not Applicable"?
- ☐ Have you completed a criminal background check?
- ☐ If you responded "Yes" to either the previous disciplinary questions or criminal activity questions, have you included your letter of explanation and certified documents in an envelope sealed by the court or agency involved, or requested that the certified documents be sent directly to the Georgia Board of Nursing.
- ☐ Include official sealed transcript



**OFFICE OF SECRETARY OF STATE
PROFESSIONAL LICENSING BOARDS DIVISION
GEORGIA BOARD OF NURSING
237 Coliseum Drive
Macon, Georgia 31217
(478) 207-2440**

CONSENT FORM

I hereby authorize the Georgia Board of Nursing ("Board") to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

Full Name (Print)

Physical Address (P.O. Boxes NOT Accepted)

Sex

Race

Date of Birth

Social Security Number

One of the following must be checked:

- ☐ This authorization is valid for 90/180/____ (circle one) days from date of signature.
- ☐ I, _____ give consent to the Board to perform periodic criminal history background checks for the duration of my licensure with this state.

Signature of Applicant

Date

Special licensure provisions (check if applicable):

- ____ Working with mentally disabled
____ Working with elder care
____ Working with children

DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS

APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

_____ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____ A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____ A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____ A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____ A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS)(Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

(Print Name)

(Signature) (Date)

GEORGIA BOARD OF NURSING

237 Coliseum Drive
Macon, Georgia 31217

**VERIFICATION OF EMPLOYMENT FOR APPLICANTS FOR LICENSURE BY EXAMINATION
GRADUATES OF NONTRADITIONAL NURSING EDUCATION PROGRAMS**

Instructions:

1. Applicant: Only Complete and Sign Section I.
2. Submit this form to your employer to verify the numbers of hours worked. List all employment (Personnel Director, Human Resources Department) that can provide verification. Ask the employer to complete this form and place it in a sealed envelope for you to submit with your application.

Section I (To be completed by applicant)

*The name and address of your employer on this form must match the name and address you listed under "Employment History" on the application.

Printed Name of Applicant: _____

Last

First

Middle

Maiden

Applicant's Address: _____

Street

City

State

Zip Code

RELEASE: I do hereby consent to and authorize the release of any and all records and information concerning my employment to the Georgia Board of Nursing. I understand this information is required as part of the application for licensure process.

Signature of Applicant _____ **Applicant Phone Number (s)** _____

APPLICANT – DO NOT WRITE BELOW THIS LINE:

Section II (To be completed by person verifying employment):

Instructions:

1. Complete Section II of this form.
2. **You must respond to all questions or this form will not be accepted by the Board office.**
3. Employment must have been for compensation.
4. Each title held with one employer requires a separate verification form completed.
5. Return the form to the applicant in a sealed envelope.

1. Name of Facility/Business/Employer: _____ Phone Number: () _____

Is this a federal agency of the United States Government?

☐ No Yes ☐

Is this an acute care inpatient hospital?

☐ No Yes ☐

Is this a long term acute care facility (LTAC)?

☐ No Yes ☐

Is this an ambulatory surgical center or obstetrical facility as defined in O.C.G.A. §31-6-2?

☐ No Yes ☐

Is this a skilled nursing facility which has at least one hundred (100) beds and provides health care to patients with similar health care needs as those patients in a long term acute care facility?

☐ No Yes ☐

2. Physical Address of Location: _____

City

State

Zip

3. Employee's Position/Title: _____

4. Is an LPN license a qualification/requirement for employment in this position? ☐ No Yes ☐

5. Identify the actual physical location where the employee practiced to include facility name, city/state if different than # 2 above or indicate same as above:

6. Employment Dates: From: _____ (mo/yr) - To: _____ (mo/yr)

Were there any periods of extended absence during employment? ☐ No ☐ Yes ☐ If "yes" please provide dates: _____

LIST BELOW THE NUMBER OF HOURS WORKED PER YEAR AND Job Description: List below the number of hours worked per year and duties:
Please note that calculation of hours worked may not include night duty hours in a skilled nursing facility

Year	Hours worked	Job Description

7. Printed name and title of person verifying employment: _____

8. I hereby certify that I am a custodian of records at _____ and the information submitted on this form are a true and correct statements of this applicant's employment with our facility.

9. Signature of employer representative completing this form: _____ Date _____

Employer Representative's Signature Must Be Notarized

Sworn to and subscribed before me this

_____ day of _____, 20 _____.

(Notary Public)

My Commission Expires: _____

(Notary Seal)

Affidavit Regarding Citizenship

Please submit this document along with a copy of your secure and verifiable document to the Board office as indicated on the application.

Print Name: _____

APPLICANT AFFIDAVIT:

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Board for which I am applying for licensure and I agree to abide by these laws and rules.

By executing this affidavit under oath, as an applicant for a professional license, as referenced in O.C.G.A. § 50-36-1, administered by the Professional Licensing Boards Division, the undersigned applicant also verifies one of the following with respect to his/her application for a public benefit (check one):

- 1) _____ I am a United States citizen. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or document as indicated on the Board's website.**
- 2) _____ I am not a United States citizen, but I am either a legal permanent resident of the United States or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

In making the above representations under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute. I also understand that any failure to make full and accurate disclosures may result in disciplinary action by the Board for which I am applying for licensure.

Executed in _____ (city), _____ (state).

Signature of Applicant

Printed Name of Applicant

SUBSCRIBED AND SWORN BEFORE ME ON THIS THE

___ DAY OF _____, 20___

NOTARY PUBLIC My Commission Expires: